



INAPPROPRIATE INVOLUNTARY ADMISSIONS TO PSYCHIATRIC HOSPITALS

P L van der Merwe, A Allan, M M Allan

Background. In order to preserve scarce resources, treatment in tertiary psychiatric hospitals should be restricted to those whose treatment needs make admission to such hospitals essential. However, anecdotal evidence suggests that a number of patients involuntarily admitted to tertiary psychiatric hospitals are discharged within 7 days of admission. The aim of this study was to identify the legal and clinical reasons that contribute to this situation.

Method. The first stage involved reviewing the mental health legislation and psycholegal literature. Thereafter we undertook a retrospective study of the records of the patients involuntarily admitted to Stikland Hospital, a tertiary psychiatric hospital in the Western Cape. Treatment and security-related variables were compared for the ≤ 7 day and ≥ 8 day groups.

Results. Eighteen per cent of involuntarily admitted patients were discharged within 7 days. The ≤ 7 day group differed significantly from the ≥ 8 day group in terms of gender, age, substance abuse history, diagnosis and previous admissions. There were more male patients, younger people, and individuals with a history of substance abuse in the ≤ 7 day group, while more patients in the ≥ 8 day group had a diagnosis of schizophrenia or bipolar mood disorder.

Conclusions. This study of involuntarily admitted patients in a tertiary psychiatric hospital demonstrated that a small but notable group was discharged within 7 days of admission. The data do not allow us to determine exactly what caused this situation, and further research at primary and secondary level is necessary in order to clarify this.

S Afr Med J 1999; 89: 1303-1307.

At a time when government spending on health is being drastically reduced,¹ it is difficult to provide high-quality patient care. In mental health this coincides with the finding of the Department of Health² that 'in the majority of psychiatric hospitals in South Africa the condition of the buildings are unacceptable for human occupation' and that 'the nurse-patient ratio is also unacceptably low'. One way of providing an efficient service under these circumstances is to use local day hospitals and regional secondary hospitals optimally before referring to tertiary hospitals. This implies, *inter alia*, that patients admitted to tertiary hospitals should be those who are severely ill, difficult to treat, or whose diagnoses are uncertain. The admission of other patients should be to regional general hospitals if the necessary facilities are available to deal with their treatment and security needs.

Anecdotal evidence is that tertiary psychiatric hospitals discharge a relatively large number of involuntarily admitted patients within the 7-day period provided for in section 18(2) of the Mental Health Act (MHA).³ This section states that on admission all involuntary patients must be examined with regard to their mental condition. The findings must be reported to the *curator ad litem* within 7 days of admission. Where someone is discharged as an involuntary patient this indicates that in the opinion of the superintendent the patient failed to meet the requirements for involuntary detention. This raises the question of whether admission to a tertiary institution as an involuntary patient is appropriate in the first place.

A cursory investigation revealed that many of the admissions were in fact inappropriate. Our theory was that three factors contributed to this. Firstly, the general practitioners, primary and secondary health workers, magistrates, and other role-players, such as the police, lacked the skills to decide on the appropriate setting in which to manage involuntary patients. Secondly, that they lacked knowledge of the legal rules governing this process; and thirdly, that there was a lack of facilities at primary and secondary level to manage certain classes of psychiatric patients.

In response to the above scenario we studied the legal provisions that govern the admission of involuntary patients. Secondly, we did a quantitative study to determine the profile of patients admitted involuntarily to the relevant hospital during 1995. We particularly compared patients who were discharged within the first 7 days with those who remained in hospital for a longer period. The need for appropriate skills and knowledge in managing involuntary psychiatric patients had already been addressed by members of the staff of the relevant hospital. Later members of the Department of Community Mental Health also started training people in the community who interacted with psychiatric patients. This group included general practitioners, primary and secondary health personnel, magistrates and their staff, social workers, the police, ambulance personnel and any other person who

Department of Psychiatry, University of Stellenbosch, Tygerberg, W Cape

P L van der Merwe, MB ChB

Forensic Psychology Programme, Edith Cowan University, Perth, Australia

A Allan, BCom, BA (Hons), LLB, MA (Clin Psych), PhD

Forensic Psychology Programme, Edith Cowan University, Perth, Australia

M M Allan, BA (Hons), MA (Psych), DPhil



was interested in attending training sessions to do with the involuntary admission process. Finally, the hospital made it easier for any of the abovementioned people to consult clinicians if they needed advice regarding the management of a patient. Unfortunately we did not have the resources to determine the availability of appropriate facilities at primary and secondary level, but the role of the police in the management of psychiatric patients was studied (S Blom, E Lesch, A Allan —unpublished research, Department of Psychology, University of Stellenbosch, 1998).

In this article we report on our findings with regard to the legal and the quantitative investigations undertaken by ourselves.

LEGAL FINDINGS

The provisions of the MHA³ govern admission of mentally ill patients in South Africa. The Act provides for three broad admission categories.⁴ Firstly, patients who do not oppose admission, secondly, those who are admitted involuntarily via the criminal justice system, and finally those who are admitted involuntarily in response to reception orders issued in terms of the MHA.³ Most involuntary admissions in South Africa take place in response to reception orders issued under sections 9 or 12 of the South African MHA.³ Section 9 provides for a formal application to a magistrate, while section 12 makes it possible for superintendents to issue reception orders in emergency situations.

The subject of involuntary admissions is controversial worldwide as well as in South Africa.²⁵ In the USA legal justification for the involuntary admission of patients is contained in the principle of *parens patriae* as well as in the police powers of the state.⁶ The *parens patriae* principle provides that detention is justified if mentally ill people are in need of treatment. When mentally ill people are detained because they are at risk of harming themselves or others, it is the police power principle that is in operation. These two principles also underlie the South African MHA.⁷ Before magistrates or superintendents can issue reception orders they must be certain that the relevant patients, due to a mental illness, are a danger to themselves or others, refusing or resisting treatment, supervision and control.⁷ Two factors therefore play a role here, viz. security and treatment needs.

With regard to security, recent research has consistently demonstrated that the gender and age of the patient,⁸ a history of harm to self or others,^{8,9} a substance abuse and dependence history^{8,9} and being non-compliant with medication,⁹ are strong predictors of harm to self or others among psychiatric patients.

Factors that *inter alia* determine the treatment needs of the patient include the diagnosis, diagnostic certainty, and the number and duration of previous admissions. Like Gove and Fain,¹⁰ one would therefore expect to find that involuntary

patients suffer from more severe or chronic disorders, and that they stay in hospital relatively longer than voluntary patients. Okin,¹¹ however, found that involuntary patients had a significantly lower rate of prior psychiatric hospitalisations, and stayed in hospital for shorter periods when compared with voluntary patients. A possible explanation for these seemingly contradictory findings is that Gove and Fain¹⁰ collected their data in the 1960s, while Okin's¹¹ research took place in the 1980s. Sociopolitical and legal changes may, therefore, have influenced these findings. In South Africa no similar empirical studies have been undertaken to date.

Once the decision to issue a reception order has been made, it is then necessary to decide on the place of detention.¹² Section 9(3) of the MHA³ read with paragraph 14 of the Department of Health and Population Development's¹³ Code, instructs magistrates and judges to decide where these patients should be detained and treated. They must make this decision in consultation with the staff of the nearest psychiatric clinic, and the medical superintendent of the closest institution if they consider hospitalising the person. Section 9(5) provides that detention can be at the dwelling of a person (i.e. in single care as defined in section 10) or at an institution. An institution is defined in section 1 as 'a state psychiatric hospital or a provincial hospital'. However, according to common law principles a provincial hospital should only admit an involuntary patient if it has the necessary facilities to manage the patient. Apparently the Department of Health believes that provincial hospitals have the necessary facilities, as paragraph 9 of its codified instructions¹³ provides that mentally ill patients who need medical treatment should be admitted to general hospitals.

The place of detention is important for three reasons. Firstly, it should be in a setting where the patients' rights, such as their right of liberty, are infringed as little as is reasonably possible.⁴ In the past the appeal courts have also warned about the danger of stigmatisation of those who are admitted to psychiatric hospitals.¹⁴ Secondly, it is important to use scarce resources, such as highly qualified mental health nurses and practitioners, wisely. Thirdly, the setting must ensure that the detention will be as therapeutic as possible.

The decision regarding whether to admit a patient to a psychiatric or a general hospital should be determined by clinical factors. As Crowder and Klatte¹⁵ pointed out: 'the selection of patients for the general hospital psychiatric unit should be dependent on the patient's symptomatology and the resources available on the unit at a given time, regardless of legal status'. Leeman and Berger¹⁶ suggested that the following patients might be suitable for care in a locked psychiatric unit of a general hospital: (i) acutely psychotic or suicidal patients, either unwilling to be hospitalised or dangerous because of poor impulse control, who are likely to benefit from short-term treatment; (ii) patients who are violent or suicidal only while



intoxicated; and (iii) patients admitted involuntarily because of their psychiatric illness, who also have acute medical problems that require care in a general hospital.

QUANTITATIVE STUDY

Method

In the course of this retrospective study we examined the records of a tertiary psychiatric hospital in the Western Cape Province that serves both metropolitan and rural districts. The study population consisted of all the involuntary admissions to the hospital from 1 January 1995 to 31 December 1995.

We noted biographical information for all patients as well as the section, i.e. 9 or 12, which authorised their admission. We also collected data for the following variables: with regard to security we looked at gender, age, compliance with medication, history of substance abuse, and risk of harm to self and others; with regard to treatment needs we looked at history of previous admissions, discharge diagnosis (*Diagnostic and Statistical Manual-IV*¹⁷), and diagnostic uncertainty at time of admission. For the purposes of this study we considered a differential or deferred diagnosis to be indicative of diagnostic uncertainty.

Data were collected from the hospital's patient indexing system and individual patient files. A very important source of information was the affidavit made by the person who applied for involuntary admission. Information regarding the compliance of patients was so poor that we decided to ignore it. Data in the patient file were complete with regard to previous admissions to that hospital, but it is possible, though unlikely, that the data may not have reflected the patient's admissions to other psychiatric hospitals.

Statistical analysis

The data are presented in frequency tables, and two-tailed chi-square analyses were used to calculate statistical significance of comparisons between the ≤ 7 day and ≥ 8 day groups. Values of $P \leq 0.05$ were considered statistically significant.

Results

The total number of involuntary admissions to the relevant hospital for the 1995 calendar year was 541. This figure represents 26.7% of all the admissions to the hospital for that year. Only 518 (of 541) cases had sufficient data to be included in this study. Table I gives the characteristics of the sample.

Of the 518 patients, 93 (18%) were discharged within 7 days of admission, 33 of them within the first 3 days. When the ≤ 7 day group was compared with the ≥ 8 day group, a number of significant differences were found. As shown in Table II, the two groups differed significantly in terms of gender, age, substance abuse, diagnosis and previous admissions. In the ≥ 8 day group there were more people with previous admissions,

Table I. Characteristics of the total group of involuntarily admitted patients

Male (%)	365 (70)
Female (%)	153 (30)
Section 9 (%)	426 (82)
Section 12 (%)	92 (18)
Age range (yrs)	16 - 90
Average age (yrs)	36
Median age (yrs)	34

Table II. Demographic and clinical characteristics of 518 involuntarily admitted patients categorised according to duration of admission

Variable	≤ 7 days (N = 93)*		≥ 8 days (N = 425)*	
	N	%	N	%
Legal status [†]				
Section 9	81	87.1	345	81.2
Section 12	12	12.9	80	18.8
Gender [‡]				
Male	76	81.7	289	68.0
Female	17	18.3	136	32.0
Age [§]				
Under 21	2	2.2	17	4.0
21 - 40	72	77.4	267	63.0
41 - 60	18	19.4	113	26.7
Over 60	1	1.1	27	6.4
History of substance abuse [¶]				
Yes	45	49.5	133	31.7
No	46	50.5	286	68.3
Risk				
Danger to others	79	86.8	357	77.7
Self-harm	5	5.5	9	2.1
No risk reported	7	7.7	53	12.6
Previous admissions ^{**}				
None	59	64.1	196	46.3
One or more	33	35.9	227	53.7
Diagnostic certainty on admission ^{**}				
Specific diagnosis	49	55.1	190	46.1
Differential/deferred	40	44.9	222	53.9
Main diagnostic groups ^{**}				
Substance-induced	63	67.7	86	20.8
Schizophrenia	9	9.7	165	39.9
Bipolar mood disorder	4	4.3	96	23.2
Other	17	18.3	67	16.2

* Totals in some categories are less than N because of unavailable data.

† df = 1, $P = 0.176008$.

‡ df = 1, $P = 0.008612$.

§ df = 1, $P = 0.017201$ (≤ 40 years v. ≥ 41 years).

¶ df = 1, $P = 0.001317$.

|| df = 1, $P = 0.096289$ (Self-harm v. danger to others).

** df = 1, $P = 0.183432$ (Self-harm and danger v. no risk reported).

** df = 1, $P = 0.001976$.

** df = 1, $P = 0.125718$.

** df = 1, $P = 0.000000$ (Substance-induced v. schizophrenia and bipolar mood disorder).



while there were more male patients, younger people, and individuals with a history of substance abuse in the ≤ 7 day group. Significantly more patients in the ≤ 7 day group had a diagnosis of substance-induced disorder, while significantly more patients in the ≥ 8 day group had a diagnosis of schizophrenia or bipolar mood disorder ('bipolar').

Further investigation of the affidavits of the ≤ 7 day group revealed that while only 49.5% of applicants reported substance abuse, the diagnosis recorded on discharge was substance-associated for 67.7% of the patients.

The groups showed no significant differences in terms of the nature of the risk necessitating the issuing of the reception order. Danger to others, as opposed to self harm, stands out clearly as the most predominant cause for an application for involuntary admission. Risk of danger to others was reported on the affidavit for more than 85% of the patients in both groups.

Discussion

This study reveals that almost one in every five patients admitted to the relevant tertiary hospital as involuntary patients during 1995 were discharged within 7 days of admission. When the legal status of this group was compared with that of the ≥ 8 day group, no significant difference emerged, which indicates that it made no difference whether patients were admitted routinely or as emergency cases.

Treatment needs do not explain the admission of the ≤ 7 day group either. This group did not differ from the ≥ 8 day group with regard to diagnostic uncertainty. Fewer previous admissions and the types of diagnoses made in the ≤ 7 day group indicate that the patients in that group were generally less severely or chronically ill.

However, an examination of the security needs is enlightening. For all the study's criteria (gender, age and history of substance abuse), the ≤ 7 day group was a higher-risk group. The only criterion where this group did not differ significantly from the ≥ 8 day group was in terms of reports of previous harm to self and others. In fact such reports were high for both groups, namely 86.8% for the ≤ 7 day group, and 85.2% for the ≥ 8 day group.

The common factor with regard to treatment and security needs is substance abuse. This study did not allow us to identify the most commonly abused substances in the relevant hospital's catchment area. However, the South African Community Epidemiology Network on Drug Use¹⁸ reports that alcohol (77%) and cannabis or a combination of cannabis and mandrax (15 - 19%), are the substances most commonly abused in the Cape Town metropolitan area.

There is a close link between psychiatric problems and substance abuse. Research in other countries shows that most patients who need emergency psychiatric treatment are young males with substance-induced disorders.¹⁹ There is also a high comorbidity of mental disorders with substance abuse.²⁰

Substance abuse may also precipitate mental illness in vulnerable individuals, e.g. schizophrenia may be precipitated in cannabis abusers.²¹

Distinguishing between cases where the primary mental health problem is substance abuse, and cases where it is for example, schizophrenia or bipolar mood disorder, will always be difficult. However, most of the patients in the ≤ 7 day group were ones that Leeman and Berger¹⁶ considered suitable for care in a locked unit of a general hospital. Even if they are agitated and aggressive, it is normally possible to manage such patients effectively in a general hospital by sedating them for an appropriate period of time. This makes it possible to re-evaluate them when they have sobered up. If the patient has not improved substantially after approximately 36 - 48 hours, it is often an indication that there might be an underlying mental disorder. It is preferable that patients with substance-induced disorders should be managed in a general hospital. While these patients present with psychiatric symptoms, such as psychosis or delirium, they are often also medical emergencies, especially if they are still intoxicated or in withdrawal. In most cases admission to a general hospital as a patient with an actual or potential medical emergency is the most appropriate course of action.

The findings of this study suggest that there is a failure at primary and secondary level to manage younger male patients with substance-induced disorders. Several factors may contribute to this state of affairs. Firstly, it may be that practitioners who complete medical certificates during the reception process are failing to identify substance-induced disorders. Secondly, it may be that the practitioners fail to advise magistrates about the most appropriate way of managing patients with substance-induced disorders. Thirdly, it is possible that primary and secondary workers are unwilling to treat young male patients with substance-induced disorders. This is a difficult group of patients to manage as they have a high propensity to be aggressive, and there may be a tendency to overemphasise the need for security. It is also possible that primary and secondary workers believe that the facilities at general hospitals are inadequate to manage these patients.

CONCLUSION

The review of legal sources in this study demonstrated that the legislator, judiciary and psycholegal authors support the diverting of patients away from tertiary mental health institutions in appropriate cases. This retrospective survey of patients involuntarily admitted to a tertiary hospital demonstrated that one in every five patients was discharged within 7 days of admission. This small but notable group was made up mostly of male patients between the ages of 21 and 40 years, with just over two-thirds of them diagnosed as having substance-induced disorders.



It is submitted that most of these patients could have been managed effectively in a general hospital. This would have represented a more optimal use of the available resources and would have been legally more appropriate. The data do not allow us to determine exactly why these patients were not admitted to general hospitals in the first place, and further research at primary and secondary level is necessary in order to clarify this. However, our hypothesis is that there are two reasons. Firstly, that primary and secondary workers either lack, or believe they lack, the necessary knowledge and skills to identify and manage young male patients with substance-induced disorders. Secondly, that the facilities to deal with this group of patients in general hospitals are inadequate. It is important that both these possibilities should be examined further and addressed if necessary.

The authors wish to thank Dr Miles Bowker, Mrs M Stein, Mrs J Barnes and Dr H de Wet for their valuable assistance.

References

- Spencer Jones J. Western Cape bites the bullet. *S Afr Med J* 1996; **86**: 1362-1364.
- Department of Health. *Report on Human Rights Violations and Alleged Malpractices in Psychiatric Institutions*. Pretoria: Department of Health, 1996: 88-89.
- South African Mental Health Act No. 18 of 1973.
- Allan A. The Mental Health Act 18 of 1973. In: Stein D, Van Kradenburg J, Wessels CJ, Emsley RA, eds. *Mental Health Resource Guide of South Africa*. Tygerberg: University of Stellenbosch, 1998: 128-140.
- Haysom N, Strous M, Vogelman L. The mad Mrs Rochester revisited: The involuntary confinement of the mentally ill in South Africa. *South African Journal on Human Rights* 1990; **6**: 341-362.
- Appelbaum PS, Gutheil TG. *Clinical Handbook of Psychiatry and the Law*. Baltimore: Maryland, USA: Williams & Wilkins, 1991.
- Allan A, Allan M. The right of mentally ill patients in South Africa to refuse treatment. *South African Law Journal* 1997; **114**: 724-736.
- Monahan J. Clinical prediction of dangerousness. *Currents in Affective Illness* 1991; **10**: 5-12.
- Torrey EF. Violent behaviour by individuals with serious mental illness. *Hospital and Community Psychiatry* 1994; **45**: 653-662.
- Gove WR, Fain T. A comparison of voluntary and committed psychiatric patients. *Arch Gen Psychiatry* 1977; **34**: 669-676.
- Okin RL. The relationship between legal status and patient characteristics in state hospitals. *Am J Psychiatry* 1986; **143**: 1233-1237.
- Kermani EJ. *Handbook of Psychiatry and the Law*. Chicago, USA: Year Book Medical Publishers, 1989.
- Department of National Health and Population Development. *Codified Instructions: Mental Health Act, 1973 (Act 18 of 1973). For use in the Department of Justice*. Pretoria: DNHPD, 1992.
- Rutland v. Engelbrecht, 1957(2) SA 338 (A).
- Crowder JE, Klatte EW. Involuntary admissions to general hospitals: Legal status is not the issue. *Hospital and Community Psychiatry* 1980; **31**: 325-327.
- Leeman CP, Berger HS. The Massachusetts Psychiatric Society's position paper on involuntary psychiatric admission to general hospitals. *Hospital and Community Psychiatry* 1980; **31**: 318-324.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. Washington DC: APA, 1994.
- Parry CDH, Bhana A. *Monitoring Alcohol and Drug Abuse Trends. Highlights and Executive Summary, Vol. II. A report by the South African Community Epidemiology Network on Drug Use*. Tygerberg: Medical Research Council, 1997.
- Szuster RR, Schanbacher BL, McCann SC. Characteristics of psychiatric emergency room patients with alcohol- or drug-induced disorders. *Hospital and Community Psychiatry* 1990; **41**: 1342-1345.
- Regier DA, Farmer ME, Donald SR, Locke BZ, Keith SJ, Judd LL, Goodwin FK. Comorbidity of mental disorders with alcohol and other drug abuse. *JAMA* 1990; **264**: 2511-2518.
- Andreasen S, Allebeck P, Engström A, Rydberg U. Cannabis and schizophrenia: A longitudinal study of Swedish conscripts. *Lancet* 1987; **26**: 1483-1486.

Accepted 20 May 1999.

SUBSTANCE MISUSE IN YOUTH ADMITTED TO A PSYCHIATRIC EMERGENCY UNIT

D A B Wilson, A J Flisher, R Allin, J A Laubscher

Objectives. To investigate the pattern of substance misuse in youth admitted to a psychiatric emergency unit of a major hospital, and to compare regular users of cannabis, methaqualone and alcohol with the rest of the sample in terms of selected psychosocial variables.

Study population. Consecutive patients aged 25 years or younger admitted to a psychiatric emergency unit over a 3-month period.

Method. Patients completed a standardised questionnaire containing questions about their family, social, economic and educational backgrounds. Their current psychiatric folder was examined to ascertain mental state and behaviour on admission as well as previous psychiatric contacts and hospitalisation. Particular attention was paid to the use of cannabis, methaqualone and alcohol. For each substance patients were divided into two groups, namely those who did not use the substance or who used it infrequently, and regular users. Unadjusted odds ratios were used to document the relationship between substance use and the selected psychosocial variables.

Results. One hundred and fourteen patients were assessed, of which number 61 (53.5%) were male and 98 (86%) were single. The group consisted of 37 blacks (32.5%), 56 coloureds (49.1%) and 21 whites (18.4%). Alcohol was regularly used by 30 patients (26.3%), cannabis by 29 (25.4%), methaqualone by 11 (9.6%), and any of these substances by 46 patients (40.4%). Unadjusted odds ratios showed that there was a significant association between regular use of alcohol and cannabis and male gender, dropping out of school, previous psychiatric treatment, and an absence of both depression and suicidal ideation; and between regular cannabis use and bizarre behaviour, auditory hallucinations and disorganised or incoherent

Department of Psychiatry, University of Cape Town

Don Wilson, BSc, MB ChB, FCPsych (SA)

Alan J Flisher, MSc, MMed (Psych), PhD, FCPsych (SA), DCH

Department of Pharmacology, University of Cape Town

Rosemary Allin, MSc

Medical Research Council, Bellville, W Cape

J A Laubscher, MSc